

Article

Teaching Staff and Student Perceptions of Staff Support for Student Mental Health: A University Case Study

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Abstract: Background: There are significant concerns for student mental health in higher education. New factors affect student mental health, and campus counselling services are overwhelmed. Struggling students turn to ideally placed familiar teaching staff for support. This qualitative study, conducted in an East of England university, aimed to explore student and staff perceptions of support offered by teaching staff to students grappling with their mental health. It is unique, combining both staff and student perceptions, many of which overlapped. Methods: A thematic analysis was conducted of in-depth, semi-structured interviews with a small number of self-selecting staff/students. Findings (results): Staff felt inadequate in several aspects, and students agreed to give useful suggestions for their preferred support. Conclusions: It was cautiously established that staff training in mental health literacy (knowledge, skills, attributes, and understanding) was required. Specific training was recommended in pastoral care for personal tutors and for staff pedagogy on health professional programmes. Finally, teaching staff needed support when supporting students with poor mental health. Such training and support can be integrated into a preventative, university-wide, holistic policy for student mental health commensurate with the University Mental Health Charter. Embedding such supportive practice into the curriculum is preferable to add-on services and/or interventions.



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Keywords: students; higher education; mental health; teaching staff; personal tutors; healthcare programmes; pedagogic practice; university policy; qualitative study

1. Introduction

Student mental health is an increasing problem in universities world-wide, likely even more so since COVID-19, and recognised as a public health issue [1–3]. A survey of 19 colleges across eight countries (Australia, Belgium, Germany, Mexico, Northern Ireland, South Africa, Spain, United States) estimated the prevalence and basic sociodemographic correlates of common mental disorders in the first years ($n = 14,000$) [4]. One in three struggled with mental health, mostly major depressive disorders. Lifelong symptoms were experienced by 21.2%, and 18.6% had general anxiety disorders. Reports from Australia [5], Canada [6] and the US [7] raised concerns about students' wellbeing and mental health. Of US undergraduates 83% are 18–24 years old [8], an age group vulnerable to mental health issues, and the UK undergraduate population has a similar percentage [9]. Seventy-five percent of mental health problems are established by 25 years [10] and are increasing [11]. Apart from the age of onset, there are new reasons for the increase in UK student mental health needs [12].

In the past 10 years there has been a five-fold increase in poor mental health in UK university students [13]. The numbers reporting poor mental health [14,15] and the demand for services have increased [13]. These students are at risk of reduced educational outcomes, including prolonged study, withdrawal or course failure [16]. Over one fifth disclosing their diagnosis reported it had begun at university, three quarters remaining affected [17]. More than one-third reported a serious psychological issue requiring professional help,

up 0.9% from 2017. In 2019 only 1.2% of students were never/rarely anxious, and 33% reported often/always feeling isolated/lonely, correlated with anxiety [18].

It was not the pandemic which changed most prospective students' views on the importance of mental health services (74%), this was already their view [19]. The pandemic has escalated the priority students now give to mental health (45%), and they value discussions and decisions by faculty and peers (*ibid.*). The proportion of UK first years disclosing was 2% in 2015/16, five times that in 2006/07. In 2015/16, over 15,000 first years reported difficulties with mental health compared to about 3000 in 2006 [15]. Only 27% thought their university provided adequate mental health support [20].

In Higher Education Institutions (HEIs) 94% revealed an increase in demand for counselling, of which 61% increased more than 25% [13], yet only 48% of UK HEIs had appropriate policies in place [21]. Reactive and individual services cannot meet the demand [22] and fail to address institutional and cultural processes influencing individual mental health [23]. The University Mental Health Charter (*ibid.*) calls for strategies to improve student mental health. Consequently, there is an urgent need to develop resources across universities to address this rising issue.

When in distress, students turn to faculty staff with whom they have a relationship [24–26]. Teaching staff are ideally placed to notice students with such concerns. Yet staff and personal tutors (allocated to students offering pastoral care/academic advice) supporting student mental health often go unrecognised. Staff can become overloaded, often lacking relevant training [25] and being confused about their role and what they can do, which creates some risks; assuming meetings are confidential when they cannot be so [22,26]; and having difficulty in distinguishing between academic and pastoral/personal problems [27]. Academics are well-placed but ill-equipped to effectively help due to stigma, lack of skills, weak mental health literacy [25,28,29], workload [30] and/or their own mental health needs [28]. Given the severe consequences poor mental health has on health, social life, academic performance, retention and employment, research contributing to a more effective provision from staff is pressing.

Mental health is usually construed in a framework of wellbeing implying links between student experience and achievement. Wellbeing is a condition for learning [31].

In a survey of 96,000 students, 10% cited depression as one of 10 obstacles to academic achievement [32]. Student withdrawal due to depression is linked to lower marks in the US [33], and in Canada emotional competencies were associated with higher academic achievement in the first years [34]. Reduced mental health can be a barrier to academic progression, warranting wide-reaching identification, treatment and outreach work for student success [35,36]. Stress is a factor affecting academic performance [37] and can be mediated by learned resourcefulness [38]. Depression significantly impacts on student achievement, and there are close links between educational outcomes and mental health [39] and between health and wellbeing [40–43].

2. Materials and Methods

2.1. Setting

This in-depth exploratory qualitative case study [44] was undertaken at a university based in a small town in the South-East of England. In January 2021 most students (70%) were 18–25 years old; 11.75% declared a disability (including mental health); 0.5% gender reassignment; 18% BAME; 55.12% were female, 44.88% were male; and 3.75% identified as LGBT+. In the 2019 National Student Survey university scores were only 1.03% below the sector, but student comments on lack of support/availability of academics for personal issues, including mental health, increased. Of students declaring a disability, the highest for non-continuation was mental health (28%).

2.2. Student–Staff Partnership Research Team

This comprised two professionals from student wellbeing services and four students from psychology and humanities. The author, professionals and under/postgraduate

students wanted to help nurture wellness, build a more effective university experience for students, and create opportunities for dialogue and action on student mental health in a student-staff partnership across the university [45]. The postgraduate student was trained and supervised by the researcher in briefing participants about the study and in interviewing and thematic analysis skills, another student was trained in briefings and arranging interview/focus group appointments, and another acted as a peer reading the report and offering critical comment. All team members were familiar with the setting, being either staff members or students.

2.3. Study Aim and Research Questions

Aim: To gain a greater understanding of (a) student experiences when in receipt of support from teaching staff for their mental health, and (b) those of the academics supporting them. **Questions:** (1) What are the perceptions of students of the mental health support received from staff? (2) What are the perceptions of staff of providing support for student mental health needs?

2.4. Study Design

The methodology was qualitative, since the research question concerned perceptions/experiences. Qualitative research is mainly based on humanistic psychology theories [46] which see knowledge as being constructed intersubjectively [47]. Methods inspired by phenomenology [48] have been developed from thorough descriptions emphasising that interpretation is inherent in experience. The aim of phenomenological research is to explore experiences and meanings and ‘to capture as closely as possible the way in which the phenomenon is experienced within the context in which the experience takes place’ [49]. The rich descriptive narratives derived from data give an appearance of participants’ lived world experience. The two sources of data (student and staff interviews) provided for a method of cross-checking by analysing them alongside each other to search for regularities, and/or differences. The findings can be assessed for trustworthiness and credibility [50] if the reader finds them believable, consistent, applicable, credible and useful.

Discussing findings at group-level is useful for understanding which experiences are commonly shared. It is acknowledged that the underlying philosophy of phenomenological research is that experience is individual and idiosyncratic, and as such each story of experience is respected. The discussion includes atypical lone voices where appropriate for a broader insight.

2.5. Sample and Recruitment

This was a self-selected purposeful sample. Volunteers were recruited by digital signboards, intranet newsfeed, posters, learning resource centres, schools, student union, word-of-mouth and staff email. The inclusion criterion was that they had to be either students or staff members of the university. There were no exclusion criteria.

2.6. Procedure

Following the distribution of participant information sheets and a briefing, informed consent was obtained. Volunteers completed application forms for demographics distributed by a student member of the research team. Thereafter, an undergraduate, and employed, student arranged a briefing session for the volunteer with one of the interviewers to go through the participant information and informed consent, after which an interview appointment was made. The interviews were semi-structured and audio-recorded, and the staff focus group was also audio-recorded. The analysis of data followed the transcription process. All participants received a copy of the interview transcription for comment and confirmation of accuracy.

2.7. Data Collection

For assessment purposes, diversity demographics were collected. To understand how staff experienced supporting student mental health, 17 faculty staff and two e-learning technicians (engaged with students) were individually/group interviewed. To understand the students' experience of such support, the six volunteer students were interviewed.

2.8. Demographics

Most staff were in their 50s, perhaps indicating they had a career in a profession before they came to HE and/or had been working in that same role for a long time. They came from a variety of schools, with mixed genders (albeit most were female, which is representative of the setting) and were across the age range and lecturing roles (see Table 1 below).

Table 1. Demographics for staff.

Programme	Gender	Ages	Ethnicity	Role
Undergraduate & Postgraduate:				Senior lecturer—7 Lecturer—1
Health care—5				Visiting lecturer—1
Engineering & technology—2		30s—3	White British—11	E-learning technicians—2
Business—2	13—F	40s—4	White Irish—1	Programme leader—2
Law—2		50s—8	Caucasian—1	Research Fellow—2
Education—2	4—M	60s—1	Black British—1	Professional lead—1
Computer		Unreported—1	Asian—1	Academic co-ordinator—1
Sciences—1			Unreported—2	Associate Dean—0
Learning & Teaching Institute—2				Professor—0
Psychology—1				Dean/professor—0

In contrast to the schools from which staff volunteered, there were no students from the health professions, but, as with staff, students were mostly female, with only one male. Assuming students volunteered due to their experience with poor mental health, it may have been the case that other students felt stigmatised and so were unwilling to volunteer. Most were female, which supports the literature stating that more female students present with the most common conditions of anxiety and depression in this age group. The male had suicidal tendencies, which is also in line with the literature. Despite the small number of students (7), there was a range across the different schools, and undergraduate years and ages were as normally found in undergraduate programmes. This can be viewed as sufficient for reaching saturation levels, especially when the interviews were 1.5–2 h in duration, resulting in rich, thick descriptions. The number is also proportionally commensurate with the percentage of students found in the literature experiencing poor mental health. There was a mix of ethnicity to some extent, although it is acknowledged that Black and minority ethnic groups were under-represented. This may be concerned with cultural beliefs about mental health and research, demonstrating that around half of students do not disclose their poor mental health [51] and that both might have been barriers to volunteering (see Table 2 below).

Table 2. To show demographics for students.

Programmes	Gender	Age	Ethnicity	Year of Study
Undergraduate:				First—2
Life & Medical				Second—3
Sciences—2		18–21 years—4		Third—2
Art & Design—2	F—6	22 years—1	White British—6	(Returned from
Business—1	M—1	24 years—1	British/Dutch—1	resting for mental
Humanities—1		3 years—1		health reasons—1
Astronomy,				Withdrew for mental
Physics,				health reasons—1)
Mathematics—1				

2.9. Measures

2.9.1. Interviews and Focus Group

For staff the initial interviews were open-ended questions (see Supplementary Materials) derived from the literature (e.g., [25]), the researcher's experience and the information deduced from the research questions included: 'what are your experiences of supporting students managing mental health needs?', with prompts such as the skills required; knowledge of mental health conditions; resources available; the extent of the role/limitations; confidentiality; recording/access and knowledge/skills/understanding of signposting/referral. The initial interview schedule was adjusted over time as new issues emerged. Transcriptions of individual interviews were sent to participants for checking accuracy/additions/omissions.

One two-hour staff focus group was videorecorded employing visual imagery [52] as used in educational research. Voices silenced by textual and linguistic data collection and analysis methods [53] can be heard through arts-based and embodied methods producing new knowledge. Participants created a collage, image and posture/movement in response to the open question 'What is your experience of supporting students with their mental health?' Their reflections on this topic provoked rich interpretations. The data were transcribed in the same way as the individual interviews.

Open-ended questions derived from both the literature [25], research questions and the researcher's experience as a teaching staff member for student interviews included 'what was your experience of asking for/being offered support by staff, and of being supported by staff for your mental health needs?', with prompts such as: the expectations from staff; what they thought staff might need to know about mental health; specialist support availability; knowledge of protocols for staff recording meeting/accessing notes and confidentiality. Open-ended questions are useful for an exploratory study. The initial interview schedule was adjusted after each interview to explore emerging issues as they arose. The justification for open-ended questions in qualitative studies is that they allow researchers to take a holistic and comprehensive look at the issues, since open-ended responses enable respondents to provide more opinions, giving more diversity than is possible with closed questions [54]. The less that is known about the research problem, the less directed the interview should be. In research of a more exploratory nature, such as this study, semi-structured interviews are more effective in eliciting data. A short thematic guide was employed with some questions/topics well-known to the researcher from the literature, and others from experiences in practice. Interviews were not fixed or predetermined nor the answers predictable. The first question was a triggering one, to give the focus directly related to the research objective, followed by in-depth exploration. Other specific topics were then addressed in an open manner. Questions were built on the interviews' progress and could be put differently to interviewees according to their characteristics.

2.9.2. Analysis

A thematic analysis of the interviews/group focused on a content analysis of the 'thick description' which identified patterned meaning across data sets, examining and recording these patterns. Themes important to the description of a phenomenon associated with the research question were identified. Coding noted specific text passages linked to, or contrasting with, a common idea, allowing the indexing of the text into categories to establish themes. By systematically interpreting and coding the textual data, replicable and valid inferences were made. Each theme provided evidence from staff and student stories in the form of quotations pertaining to the phenomena in question.

The thematic analysis process followed six steps often employed in qualitative research [55]: familiarisation with data, generating initial codes, searching for themes among codes, reviewing themes, defining/naming themes, and producing the report. The analysis started during the interviews, and in transcribing them notes were made of what struck the transcriber-researcher as important. On re-reading the transcriptions, important aspects

were noted in the left margin, and the material was coded according to developing themes. Passages relevant to the research question were highlighted using coloured pens to identify the experiences of supporting students; knowledge of stress/common mental health conditions; recording conversations and access; confidentiality; role/boundaries; context of student mental health/wellbeing issues; signposting/referral; own support and recommendations. Specific words/phrases referencing these broad categories were subsequently highlighted, followed by selecting and making bold words framing the category in a more refined way, such as the contrasting ways academics recorded meetings/conversations with students. These were highlighted in red as evidence for the category and quoted in the report. Quotations evidencing a theme linked to a respondent were identified by letter and number. Arriving at the themes facilitated recommendations to inform university-wide strategies, policy and/or pedagogical approaches in supporting students.

3. Results/Findings

Staff recounted how they handled different cases, making recommendations for how their support might be more effective. Students shared examples of how well, or not, they had been supported by staff for their mental health and made suggestions for improvements.

Three themes emerged from the analysis of both data sets: the requirement for staff training (including specific training for staff on healthcare programmes); support and training for personal tutors and support for staff when supporting students.

3.1. Staff Training

The issue of staff training arose from both student and staff perceptions. Despite the availability of counselling services, students complained they had to 'wait too long for an appointment' and there was 'too much form filling', and so they sought support from staff. Staff pointed out the 'counselling service was overwhelmed', resulting in students 'not always taking up' suggestions to self-refer, so that 'the student was met with regularly in the meantime'. Another respondent mentioned the difficulty in selecting who to refer to: 'you're almost having to pick and choose which students you think need to be referred on'.

Some staff acknowledged students were unable to attend counselling for fear of judgement, placing an additional burden on staff challenging them to support students. For example: 'she's finally opened up to say that she's struggling to engage, that she's on the autistic spectrum, she didn't want to tell anybody because she feared looking like she'd be judged . . . People would talk about her contacting disability services'. For some, turning to staff on the pretence of an academic issue might be more acceptable than self/staff-referring to counselling, especially if they had had frequent contact with that member of staff via tutorials/lectures, etc.

Although most staff recognised their role of signposting, several tried it but found it far more complex than assumed. Several staff members described limitations in their understanding of, and skill in, signposting/referring to, for example, student counselling. 'I was unsure what to say if I called the counselling team [on the student's behalf]. If it is suggested to the student to do this, my feeling is they may not' and '[It] depends on whether [it is] a disability thing or a wellbeing thing. I would hope to put them in touch with the right people but would not really know'. Some staff members did not want to signpost, as they thought the student would 'feel dismissed', or 'think it was a waste of time'. For these reasons, the staff held back from signposting to counselling/disability services.

Students frequently mentioned that 'staff should have keen signposting skills'; 'be aware of the services and support structures available to students to be able to direct them or give them relevant contact information' and that referral 'depended on the context and communication'; 'staff should ask the student if they would like to be referred/signposted'. According to another queried staff authority, 'the student should have the choice' and the wording in signposting is important to reduce insecurity/fear.

Some students thought there were limits in staff providing active listening, targeted solutions and how best to deal with and understand common student mental health conditions, 'to understand some examples of mental health conditions, like different types of stress or anxiety, or know the differences between stress and anxiety, to know the symptoms'.

When staff were also trained or experienced health professionals/educators, there was confusion about their role. As a nurse or teacher, they would 'feel the responsibility to do X' but as university staff they thought 'perhaps it was not the right thing to be doing'. One asked 'Where does our professional duty stop? If I really do feel somebody is at risk, where I would still have responsibility as a nurse, so I would need to do something about that, but I wouldn't want to overstep my academic, erm, role as well'. Another health professional commented on the possibility of being pulled out of the role due to student needs: 'she's not getting the right support from the NHS team, erm, so she is trying to use us more for support'.

One student referred to stigma preventing effective support: 'staff should be aware of their own stigma. Some people have had it lucky, had a decent upbringing, and do not really know their body language and expressions can be put onto students without consciously realising this'. Perhaps due to stigma, staff expressed difficulties broaching the subject of mental health with students, for example, 'I guess it might be showing interest, or it could be I'm damaging an already established relationship by surfacing something incredibly sensitive . . . are they thinking? 'he'll never see me in the same way again' or "'he knows"—that kind of stuff'.

A major recommendation from staff was accessible and flexible training for supporting students with their mental health/wellbeing. For example, knowledge and understanding of how to take notes of a meeting—decisions on content, access, limits of confidentiality, and how to inform students beforehand of protocols. Some were unaware of the importance of making a record, and of accountability. Students did not mention this, being under the impression meetings were in total confidence, although staff did not confirm this to them. Clearer, specific guidance on their responsibilities was required, thought another staff member. For example: 'what is the university expecting us to do on the front line? Guidelines on how to record these encounters would be helpful. Confidentiality is about contact details for students. but not about conversations with us. Be more specific, give clearer guidance'. Staff members required more understanding of the distinction between teaching and pastoral roles and matters of confidentiality, indicating it would be useful 'to understand role boundaries'.

They were unsure whether they would recognise early warning signs and were unable to identify a low mental health concern, for example: 'some staff need help to even begin talking about mental health and spotting triggers'; 'I'm not sure what early warning signs might be . . . could be absence perhaps'; 'I don't know what a low mental health concern is.'. and 'I don't believe homesickness is a low mental health concern', which it could be.

Staff proposed raising awareness of student mental health and from where staff might gain advice when supporting distressed students, such as promoting telephoning the student wellbeing service if unsure of what to do/say. Others appeared unaware of this service. One student thought that a staff member appeared flustered, trying to find a resource for her.

Students wanted staff to be caring and empathic and to listen and have basic knowledge of common mental health conditions, whereas staff did not refer to attributes required to effectively support students. One student noted: 'I was well supported by the member of staff for my severe mental health disorder during a stressful period', but they did not say how. Other students, like staff members, suggested skills-training for staff such as identifying and dealing with panic attacks: 'I was having a panic attack and felt unable to breathe, the staff member was unable to guide me through it'.

3.2. Personal Tutors

Linked to staff training, but with a mixed reception from staff and students, was the role played by personal tutors. Staff suggested further training for this role; for example, '[the] personal tutor role feels quite vulnerable—would be useful to have refreshers'. Shortfalls in personal tutors supporting students safely were mentioned by several students. Their stories indicated some personal tutors appeared ill-prepared; one student suggested offering the role as 'an option would be more suitable', while another said it 'may suit some personalities and personal characteristics more than others'. One suggested the personal tutor would be better coming from a completely different faculty/school. Another thought the role 'quite vulnerable', which may 'preclude a student disclosing'.

Staff barely mentioned the pastoral role personal tutors might fulfil, although one was concerned a student could not speak to their personal tutor. 'She just won't talk to her tutor . . . She can't talk to him, whether it's because she doesn't have that trust, she's been through . . . , she doesn't feel safe'.

Students thought the personal tutor could not be the sole person for support in case the relationship was insufficient for sensitive conversations: 'when they share it with somebody and that person is not much help, then the stress multiplies it', and 'she yelled at me! It becomes so personal, it's as if just one bad experience can put you off ever expressing that sort of sentiment'. Help-seeking can be thwarted despite confiding in a personal tutor. When this relationship breaks down the student is left without support, as no system is in place to resolve it. One respondent commented that 'psychology students are worse at asking for help, because they think they should know it. And in fact, by the second year tend to be worse because they're learning more stuff about the connections, and they panic'.

Students suggested the tutor group staff member might also act as their personal tutor throughout the course (with the option to change) to encourage help-seeking or, alternatively, one 'from another course entirely'. Students thought staff needed to encourage them to speak to their personal tutor about their mental health but did not mention the extent of confidentiality. Although some staff members liaised with personal tutors, most failed to raise the confidentiality issue, and others did not think to liaise. Only one felt it 'important to gain permission from the student to speak on the student's behalf to their personal tutor'.

Most students thought personal tutors could be 'more interested in mental health/wellbeing issues' and have 'more individual meetings'. One suggested a programme 'in the first week, for first years, like that for international students, to promote friendship-making, belonging and settling in'. Attendance at personal tutor groups arose, one staff member suggested 'at induction where students ice-break, they could go into a timetabled tutor groups to ensure students attended, because if you try and do [this] outside the timetable they don't come'. The absence from the tutor group may indicate they do not require support or, as one participant suggested 'they may be fearful of attending because they need support but cannot bring themselves to request it in a group'.

Tutorials are usually provided more frequently by the tutor. Students get to know them more, and a student commented that tutorial content can support wellbeing/mental health as well as academic issues. Staff suggested bringing tutor groups together at times—for example, students meeting personal tutors for workshops in the first weeks of year one, or tutors pre-empting/normalising emotional issues, for example, explaining on arrival that 'this is going to be anxiety-provoking', 'people are going to be lonely/feel homesick at first', showing that these feelings can be viewed as normal.

3.3. Support for Staff

Some staff suggested teaching staff needed training to obtain support when helping a student and to feel confident when speaking to students about mental health. For example: 'I don't think fellow colleagues know where to find support for themselves when supporting students with mental health'.

Many staff members reported the lack of reinforcement by university systems and policies for supporting students with poor mental health. One proposed calling another staff member to debrief: 'I mean if it's just somewhere for me to bring closure, you know, I can actually say, . . . 'oh, look this was the email a student sent because of my action', erm, just somewhere to store that information rather than it just drifting off'.

Despite the student counselling service offering support to staff supporting students, few were aware of it. If staff members noticed a student struggling emotionally, most felt there was no one to speak with about their concerns; for example: 'to speak to someone knowledgeable for support'; 'to have someone with whom things could be thought through, clarifying the right action', and 'the need for some support for staff, I would say staff resilience comes into this, and wellbeing'. Opportunities to communicate with other staff members were suggested: 'everybody is quite compartmentalised and always dealing with their own thing, even inter-departmentally there is not much communication'. Depending on each school and how they operate a 'drop-in group meeting at the end of the week' was suggested to prevent isolation and nurture communication so that staff could feel as though there is support.

Another difficulty, said one student, was 'staff's mental wellbeing being disrupted at the same the time as the student sought help'. It was thought this might 'prevent them from being fully attentive and supportive'. A staff member concurred with this: 'they can't relate, respond, yea, they might be, they might find themselves in a similar situation'. Consequently, staff with reduced mental health need to be aware they themselves may require support and may not be well placed to support students. Students acknowledged that staff required support for supporting students: 'I think the lecturers need an outlet either as a group or privately'. Another student worried that staff 'seemed to be impacted by providing the support'.

Several staff members mentioned that time to support student mental health was 'unacknowledged and not provided for in their workload'. Some spent 'many hours' supporting students, resulting in 'pressure affecting their mental health'. Although students did not require a set duration for meetings, staff members were mixed in their views. Some restricted time, especially for students they believed were not genuine, while others gave the time required. All students acknowledged staff gave them the time needed, yet recognised they had other duties. Since workload allocations did not acknowledge the time, staff members gave their free time. This could be framed as overloading staff and a lack of provision to support them to provide support for students' complex emotional needs.

4. Discussion

4.1. Staff Training

An early UK report recommended that universities provide training for academic staff in recognising mental disorders and detecting suicide risks [56]. In response to the increase in students suffering from poor mental health, The Department of Education in 2018 announced a University Mental Health Charter outlining criteria for HEIs to gain recognition. Once implemented, it will recognise and reward institutions demonstrating that student and staff mental health is a university-wide priority delivering improved student mental health outcomes. Funding for innovations to combat the rise and initiate a step-change [22] in student support across the country is available [57].

Despite this, training UK HEI staff in supporting student mental health remains at an early stage. Overseas examples include studies on the effectiveness of mental health first aid (MHFA) training in the workplace in Sweden, with positive results such as clearer role boundaries, knowledge and skills concerning mental health needs, sustained at two years follow up [58]. The effectiveness of MHFA training for student affairs staff in Canada was evaluated with positive outcomes [59]. In Australia, a survey of 224 academics recommended training in mental health literacy and relevant skills to respond appropriately to students and signpost them to suitable care [29]. A qualitative study with academic and professional staff at two Australian universities documented experiences of their

supportive role [60]. Staff recognised the personal/organisational challenges of the role. Recommendations included training in mental health and the acknowledgement of the hidden role and workload to ensure positive outcomes for students.

The need for staff training illustrated in this study was in accord with recommendations in the literature [13,25,29,59], supporting the finding that staff required training, specifically in protocols, role boundaries and signposting/referral. Another study found some teaching staff 'struggled to be confident in signposting, rather continuing to provide support for students in distress due to concerns that something will go wrong' [25] but gave no detail. Training staff in their pastoral role, referral systems and handling crises was recommended in an earlier study, but it was added that all relevant staff need training in mental health awareness and protocols for reporting concerns, including non-academics [13].

Students mentioned that stigma can inhibit help-seeking and disclosure. Stigma associated with mental health is not only associated with staff. More than three-quarters (78.1%) of students reported that they had concealed their symptoms from those around them (family and friends) for fear of stigmatisation—a 3% increase [61]. However, a USA study [62] found upward trends in mental health service utilisation on campuses over the past 10 years, indicating more disclosure. The numbers of those seeking counselling have increased in the UK, but the threshold for appointments is high [13,28]. Since services focus on severe mental illness, access is reduced for the majority with moderate problems [56]. Counselling services are overwhelmed [13], perhaps due to cutbacks, but likely linked to the increased student disclosure of stress/mental ill-health. There have been calls to create effective programmes encouraging students to discuss mental health and improve help-seeking behaviours [63]. Mental health literacy has been significantly positively correlated with help-seeking behaviour, but not with distress or wellbeing [64]. They also call for anonymous online resources to help students become more knowledgeable about mental health and comfortable with seeking appropriate support. The service shortfall results in staff taking on more of the support required for students with moderate/low-level mental health, for which this current study shows they are unprepared. An additional burden is placed on staff to fill the gap in student counselling without acknowledgement of the extra workload.

Half the staff volunteers in this study were from schools training health professionals. A UK study of staff on nursing degrees found the maintenance of boundaries was difficult due to competing academic and professional identities; student disclosure was challenging because of professional responsibilities, and supporting student mental health on placements was problematic [26]. These issues were also described by some staff in the current study. However, they were aware of the potential negative impact of course content and practice on student mental health. It is recommended that staff on these programmes be given additional support and training to help them in their provision to students.

Staff recommended that policymakers listen to staff and student opinions on the support they require for maintaining mental health, proposing an online survey to profile staff's knowledge, skill and understanding to inform future staff training needs. Students too acknowledged that training is needed for staff engaging with student mental health needs.

The combined suggestions from staff and students are listed below (see Box 1 below):

Box 1. To show the combined suggestions from staff and students.

<ul style="list-style-type: none"> • stigma awareness; • accessible and flexible training; • targeted/common solutions; • understanding of common mental health conditions and 'low' concerns; • active listening; • signposting/referral procedures; • how to confidently speak to students about mental health; • how to recognise triggers/early warning signs; • knowledge of the relevant service (the 'right' people); • liaison with student wellbeing service; • identifying and dealing with panic attacks/crises. 	<ul style="list-style-type: none"> • clarity in role, boundaries and responsibilities; • gaining permission from students on recording actions; • how to record (notes) meetings; • holding time boundaries; • limits of confidentiality; • how to inform student protocols (such as sending the record to the personal tutor); • how to obtain advice; • where to gain support for themselves; • listen to students and staff opinions on training needs for staff to effectively support student mental health, e.g., conduct an online survey to obtain a view of staff training needs and student mental health literacy
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4.2. Personal Tutor

Personal tutor research shows that most of the time spent with students is for personal development matters [65]. Poor personal tutoring has been found to be worse than providing none [66]. Personal tutors require specific training for supporting students before they require professional help, which might include (see Box 2 below):

Box 2. To show suggestions for personal tutor training content with reference to supporting student mental health.

<p>Skills in:</p> <ul style="list-style-type: none"> • coaching; • active listening; • ways to encourage tutees to speak about their mental health, being interested; • liaising with teaching staff and vice-versa; • identifying signs of mental ill-health; • referral. <p>Knowledge and Understanding of:</p> <ul style="list-style-type: none"> • resilience; • emotional regulation; • the stress-response; • risk and protective factors, • preventative strategies such as self-management • strategies promoting wellbeing and self-compassion; • boundaries between counselling and pastoral care; • the interface between personal development support and that for academic skills. <p>Additionally:</p> <ul style="list-style-type: none"> • the option for staff to volunteer for the personal tutor role; • offering personal tutors from other courses, schools, faculties; • ensuring meetings timetabled when students are on campus; • sometimes tutor groups together; • option of the same personal tutor as staff for the tutor group; • content of tutorials could include mental health, wellbeing and academic issues and normalising entering university is stressful for a while-can be lonely, feel homesick at times; • the option of training in MHFA; • more individual tutee meetings; • a tutor group programme in the first weeks promoting friendship-making & belonging.

4.3. Staff Support

Visible access to support for staff and the development of skills and mind-set to appropriately manage potential impacts have been recommended in a previous study [25]. These authors found that teaching staff responding to student mental health needs had a

‘significant, negative impact on their wellbeing’ (ibid, 9). The findings were supported in the current study—for example, student concerns impacting upon staff’s home life and emotionally and students worried staff had been affected by their own mental health needs.

A culture shift is required to transform supportive resources and frameworks for staff to improve wellbeing, and academic/research outcomes for staff, as well as students. The impact on staff wellbeing needs acknowledging in workload allocation. A practical barrier to embedding successful and effective support for students is the intensification and multiplicity of demands on staff members, and how these can impact them [67]. An environment which reduces stress and improves wellbeing should not only be for students, since 66% of academic teaching staff with reduced mental health reported that these were directly related to work [68] (see Box 3 below):

Box 3. To show recommendations arising from the findings.

- staff support for students with their mental health needs reinforcing by university policies and systems;
- staff require a trusted colleague knowledgeable about mental health with whom they can debrief/consult if required;
- optional timetabled facilitated support group for staff to discuss concerns about students (anonymously);
- more opportunities for communication about student mental health;
- recognition in staff workloads for the time to support students with their mental health needs.

UK universities are encouraged to create a healthy, preventative whole-university (holistic) environment with frequent learning events on mental health to support staff and students [69]. Staff training and self-support to effectively support student mental health can be an integral part of life at work. This approach has been advocated to resolve any mismatch between the supply and demand of services [21,70], reducing demand [23]. It can be concluded that the questions proposed elicited relevant data to make substantial recommendations, although caution must be applied when considering generalisation, due to the self-selected volunteers and the small number of students.

4.4. Limitations of the Study and Establishing Trustworthiness

The limitations include the low number of participants, which is more likely with such a sensitive topic and in an exploratory study. For example, some staff who may have had experience of supporting students with mental health concerns and some students with poor mental health who had experienced staff support would inevitably not have volunteered, resulting in recommendations perhaps not being generalisable to all students and staff. Alternatively, although there were fewer student volunteers a saturation point in their interviews was reached, despite the withdrawal of one student volunteer.

For this study to be accepted as trustworthy, it needs to demonstrate that the data collection, analysis and interpretation was conducted systematically, precisely, exhaustively and consistently, so that the reader can judge whether it is credible [50]. With reference to validity, judgements from both readers and researchers are required [71]. The study compared data from two sources—staff and students—in a form of triangulation [72]. The patterns of convergence developed an overall interpretation, thus ensuring comprehensiveness and a reflexive analysis of data [73]. Additionally, there has been an explanation of the methods employed, an account of the data collection procedures and the method of analysis, enabling the reader to assess whether the data adequately support the interpretation.

The initial interview questions for staff arose from the literature focused on staff confidence and the experience of supporting students with mental health needs. There were a few questions for staff and students which arose from the researcher’s experience, such as the issues of confidentiality, risk factors such as homesickness, reporting and staff/student communication with student wellbeing services. The initial interview schedules were

amended over time, as issues arose which required further investigation—such as those of personal tutors, support for staff and barriers to accessing student wellbeing services.

It is recognised that some questions might be viewed as being biased, since the principal researcher suggested them based on her experience and qualifications as a psychotherapist, teacher and counselling/mental health advisor supervisor in HE. Personal bias cannot be avoided [73]. However, there were two interviewers to mitigate this bias to some extent—the other being a male postgraduate student without experience or qualifications in any relevant areas of study. None of the participants had a pre-existing relationship to either interviewer. The research team and the two interviewers included all had a professional interest in student mental health [74]. Furthermore, the researcher kept a reflexive journal documenting prior beliefs, experiences and assumptions. The effects of the researcher's professional status on the data are considered a limitation in relation to the distance between the researcher and student interviewees. However, there were students engaged in briefings, making appointments and interviewing, which created less of a distance for student participants.

The design to interview both staff and students provided a range of different perspectives, as the views of one group are not presented as representing the sole truth about either student experiences of academic support for their mental health or staff experiences of providing such support in line with 'fair dealing' [72] p. 51.

Bias was also addressed through employing a large degree of self-awareness on the part of the researcher. For example, taking care not to lead or prompt the interviewee in any particular direction, examining findings against the relevant literature [75] and documenting the audit trail of the research process. This helps to demonstrate that findings emerged from the data and not the researcher's own predispositions. The researcher has admitted to relevant beliefs and experiences underpinning the decisions made and the reasons for favouring one approach over another. The open-ended questioning format helped to ensure honesty in participant responses. Additionally, they were given clear directions to the effect that no response could be wrong and that it was their authentic experiences which were important. After their interview, respondents were sent the transcriptions to check their accuracy. The methodology has been documented to enable the study to be repeated, which helps with transferability. If there had been sufficient funding, a follow-up study might have been helpful in checking that experiences were still common amongst students and staff.

Purposive sampling was used on participants who shared the characteristic of being either a staff member who had supported students with their mental health or a student having received support from staff for their mental health. Both groups had the potential to provide rich, relevant and diverse data pertinent to the research question [73]. Thus, the sample resulting from the call for volunteers was random in that only those volunteering could be interviewed. This was a limitation in that the design could have employed probability sampling to ensure the representation of the wider population. One barrier to recruiting a larger probability sample might be concerned with the stigma still associated with mental health, which may still result in too few participants. Other limitations to the sample were the absence of postgraduate student volunteers and the absence academic staff at the level of management.

With reference to credibility, there was a debriefing between the researcher, the Dean of Students and the funding staff. An internal quality audit was undertaken in which the whole team of staff and students scrutinised the report in a triangulation exercise. They resonated with the outcomes and from the perspectives of a teaching staff member and a student with mental health needs, indicating the degree of credibility to the findings. Additionally, there was a peer review of the report and this article to provide an external check on the research process' increasing credibility. Respondents could have been sent the interpretation of data as a form of 'member checking' [51,72] p. 51 for validation reducing, and another peer could have analysed the raw data, cross-checking it with the findings to reduce errors. There was a cross-check between the two interviewers' analysis of the

data in the six-phased method. This was an iterative and reflective process over time, involving a constant moving back and forward between phases and interpretations of the data. This cross-checking and peer reviewing of themes could be viewed as increasing the confirmability, which is established when credibility, transferability and dependability are achieved [76].

To enable transferability, sufficient detail of the context of the fieldwork and setting is required, as well as a 'thick description' [77], so that the reader can decide whether the prevailing environment is like another and whether the findings can justifiably be applied to this other setting [72,78]. This account has provided an overview of the setting, acknowledging it is situated in a small town in the southeast of England, which demographically and economically may not necessarily match other urban-based institutions.

Unfortunately, not all the criteria found in COREQ [77] were met in this study, which is another limitation. Trustworthiness is a way researchers can persuade themselves and readers that their research findings are worthy of attention [78]. It is hoped that the above has described the evidence of the key criteria of credibility, transferability, dependability and confirmability and goes some way towards fulfilling the assessment of trustworthiness in this qualitative thematic analysis research study, despite the limitations.

5. Conclusions

This study is exceptional in that it combined both staff and student perceptions, many of which overlapped. There were new findings which can be integrated into staff training in supporting student mental health and wellbeing and student mental health literacy education. Since other findings accorded with some of the suggestions in the established literature, it is cautiously proposed that our findings could be applied to other universities in a similar setting, in which there is staff training in supporting student mental health, whether or not it is mandatory [78]. As a preventative measure and contribution to the discourse on student mental health, from these findings and the relevant literature, university policymakers might consider:

- Training faculty staff in mental health awareness, literacy, skills, knowledge and understanding, without the requirement for them to become counsellors, to support students effectively with their mental health/wellbeing concerns. Bespoke training for staff on healthcare programmes should be considered.
- Specific training in pastoral care for personal tutors
- Support for staff in their support of students
- Develop a holistic policy for raising awareness of student mental health to help de-stigmatise mental health and ensure it comes into the foreground of the student experience.

It is hoped the study meets the criteria of acceptability and usefulness for the variety of stakeholders and that these recommendations contribute to the existing discussion on the increasing numbers of student experiencing poor mental health in HEI research, policy and practice. They can be considered as part of the policy in HEIs to help to equip staff to effectively support students, improving student engagement, academic success, experience and retention, especially for disadvantaged/minority groups. This study adds to the literature and informs geographically based larger-scale studies which are required due to the uniqueness of HEI systems globally. A staff survey on their confidence to support student mental health and a student survey on their needs for support from staff is planned. Outcomes could inform the curriculum for a staff training programme.

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study. All data has been anonymised so no research participant can be identified in this article.

Data Availability Statement: Data supporting reported results can be found in the secure One Drive at the University of Hertfordshire, accessed through the author.

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